anatomy differ between men and women who present with acute coronary ischemic syndromes.

924-35 Comparison of Lesion Morphology Producing Non Q Wave MI and Unstable Angina

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We prospectively and concurrently evaluated 73 non q MI and 196 unstable angina (UA) patients to determine the role of coronary artery (CA) lesion morphology in patient presentation and outcome. The groups (non q vs UA) were similar in gender (61% vs 66% male), age (61 ± 15 vs 62 ± 17 y), diabetes (27% vs 67%), incidence of multivessel (63% vs 67%) and left main disease (1.4% vs 4.5%). The mean number of vessels with ≥70% stenosis was 1.7 vs 1.5 (PNS). Non q MI patients less frequently had previous CABG (15% vs 29%, P = 0.023), and a previous myocardial infarction (18% vs 35%, P = 0.007), more frequently had ST depression ≥1 mm (25% vs 15%, P = 0.058) and required IV nitroglycerin for ongoing pain (64 vs 32%, P = 0.001). Non q MI patients had more CA thrombus (52% vs 19%, P = 0.001) but less ulceration (19% vs 50%, P = 0.001) and fewer Ambrose eccentric type II lesions (17% vs 51%, P = 0.001). The incidence of in-hospital MI or death was similar between groups (5% vs 8%) but refractory angina was more common in UA patients (23% vs 42%, P = 0.004). *Conclusions:* Despite similar clinical presentations, non q MI and unstable angina patients had different coronary lesion morphology with a higher frequency of thrombus formation in non q patients representing the most important distinction between the groups. The incidence of lesion ulceration in non q patients may be underestimated by obscuring thrombus. Stabilization of ulcerated plaques and prevention of thrombus formation remain important principles of treatment for both syndromes.

924-36 Antecedent Angina Pectoris and In-Hospital Outcome After Myocardial Infarction in Patients Receiving Thrombolytic Therapy: The Second National Registry of Myocardial Infarction (NRMI 2)

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Preinfarction symptom status has been suggested as an important predictor of clinical outcome after myocardial infarction (MI). Among 48,531 MI patients (pts) receiving thrombolytic therapy in the NRMI 2 study, 6,189 (13%) pts had antecedent angina (A/A), and 42,342 (87%) had no A/A. Pts with A/A were significantly more likely than those without A/A to experience recurrent MI (4.6% vs 3.3%), congestive heart failure (14.7% vs 9.8%), shock (6.2% vs 4.5%), and death (7.8% vs 5.6%) (p < 0.001) during the acute hospitalization. After adjusting for differences in various prognostic factors utilizing a multivariate regression analysis, the risk of in-hospital events in pts with A/A as compared to those without A/A is as follows:

In-Hospital Events	Adjusted Odds Ratio	95% CI
Recurrent MI	1.13	0.96, 1.31
CHF	1.21	1.11, 1.33
Cardiogenic Shock	1.19	1.04, 1.38
Death	1.03	0.91, 1.18

Conclusions: This large-scale observational study of over 48,000 patients with MI suggests that A/A is not associated with increased risk of in-hospital death or recurrent MI.

924-37 Psychological Distress Resulting from a Mosaic of Psycho-Social Variables as a Risk Factor for Acute Coronary Syndromes

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Psychological distress (PD) is a risk factor for acute coronary syndromes (ACS). The role of environmental and intrinsic components in the genesis of PD in these patients (pts) has not yet been clarified. We considered three factors eliciting PD: distress-prone coping (evaluated by the Ways of Coping Checklist), low social support (detected by the Social Support Questionnaire) and the occurrence of painful life events as assessed by a specific questionnaire. Global level of PD was determined by either the Modified Maastricht Questionnaire (MMQ) and the self-evaluation test (SE). We studied 130 pts (110 men, age 56 ± 9 years) with ACS (85 with acute myocardial infarction and 45 with unstable angina) and 102 healthy controls (C, 70 men, age 55 ± 9 years). Global level of PD was strikingly higher in pts than in C (SE = 7.1 ± 2.3 in pts vs 4.3 ± 2.4 in C, P < 0.001; MMQ = 90.5 ± 32.2 in pts vs 59 ± 30 in C, P < 0.001). Pts had higher level of social isolation (28.9 ± 11.1 vs 23.4 ± 8.8, P < 0.001), of two coping features (self-blame = 7.2 ± 1.9 vs 5.8 ± 1.6, P < 0.001, and avoidance = 21.1 ± 3.5 vs 18.9 ± 3, P < 0.001) and a higher number of painful life events (3.9 ± 3.8 vs 2.6 ± 2.2, P < 0.05) compared with C. Both in C and in pts PD was related to social isolation (p < 0.05), to specific coping features (in particular self-blame and avoidance) (p < 0.05) and to the occurrence of painful life events (p < 0.01). Overall the association of these three factors eliciting PD resulted in higher scores of MMQ in pts (49 ± 12 with no components, 76 ± 25 with one, 93 ± 29 with two and 102 ± 31 with three, P for trend <0.0001).

Conclusions: our results show that PD, caused by both intrinsic and environmental factors, is associated to ACS, suggesting that it may be a precipitating factor of these syndromes.

925 Studies of Primary PTCA in Acute Infarction

Monday, March 17, 1997, Noon–2:00 p.m.
Anaheim Convention Center, Hall E
Presentation Hour: Noon–1:00 p.m.

925-38 Is the Benefit of Emergency PTCA for Acute Myocardial Infarction Negated By Early Reocclusion Before Discharge?

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PTCA is widely used as reperfusion therapy for acute myocardial infarction (AMI), and achieves very high early TIMI-3 patency rates but the incidence of early reocclusion remains unknown.

The aim of this study was to assess infarct-related vessel patency 8 to 10 days after successful emergency PTCA of the culprit vessel for AMI. We retrospectively studied 399 consecutive Pts (aged 59 ± 3 years, 81% men, 52% anterior, from onset to TIMI-3 patency: 249 ± 96 min) admitted <6 hours after AMI onset, and successfully (TIMI-3 flow, <50% residual stenosis) treated by primary (n = 318) or rescue (n = 81) PTCA. Out of them, 277 pts (74.1%) underwent predischarge angiography (211 after primary PTCA and 66 after rescue PTCA). Among these Pts, 6 (2.8%) of the primary PTCA group and 4 (6.1%) of the rescue PTCA group had reocclusion of the infarct-related vessel. Reocclusion was silent in 80% (8/10).

	Primary PTCA n = 318	Rescue PTCA n = 81	Overall n = 399
Acute TIMI-3 flow	297 (93.4%)	77 (95.1%)	374 (93.7%)
Day 8 angiography	211 (71.0%)	66 (81.0%)	277 (74.1%)
Day 8 TIMI-3 flow	205 (97.2%)	62 (93.9%)	267 (96.4%)
Reocclusion rate (TIMI-3 to 0–1)	6 (2.8%)	4 (6.1%)	10 (3.6%) NS

Despite a potential bias (only 74.1% Pts underwent repeat angiography), it appears that patency achieved by emergency PTCA is sustained at discharge, with a low early reocclusion rate.

925-39 Prevalence and Prediction of No-Reflow After Direct Angioplasty in Acute Myocardial Infarction

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Aim of the study: To assess the prevalence of the "no reflow" phenomenon in patients with AMI following direct PTCA.

Methods: Forty three consecutive patients with AMI arriving to the emergency room within 3 hours from the onset of the symptoms (i.e., typical chest pain persisting > 30 minutes and ≥2.0 mm ST segment elevation in ≥2 contiguous leads), underwent direct PTCA between 1987 and 1995. The criterion for identifying the "no reflow" phenomenon was progressive flow reduction (TIMI flow <3 following successful PTCA and initially brisk flow, without angiographic signs of intraluminal thrombi, coronary dissection or significant residual stenosis (quantitative angiography).

Results: Recanalization of the infarct-related vessel was achieved in 39 patients. Thirty two were free from significant residual stenosis, thrombi or dissection. "No reflow" was observed in 11 of these 32 cases (34.4%). The incidence of "no reflow" was similar for LAD artery, right coronary artery and left circumflex coronary artery. Patients with "no reflow", compared with patients with normal flow, had similar mean time to reperfusion, mean heart rate, mean aortic pressure before the procedure and during the last angiographic control. Post PTCA residual stenosis was 29.8 + 12.4% in "no reflow" patients

MONDAY POSTER